# North Carolina – Treatment Outcomes and Program Performance System (NC-TOPPS)

## Advisory Committee

## October 26, 2006 Meeting Minutes

**Attendees**

Member/Representatives:

| | |
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| Sonja Bess | Mental Health Services of Catawba County |
| Dan Herr | Orange Person Chatham Consumer Family Advisory Committee |
| Connie Mele | Mecklenburg County Area MH, DD, SA Authority |
| David Peterson | Wake County Human Services |
| Andy Smitley | Sandhills Center for MH, DD & SAS |
| Diocles Wells | Southeastern Center |
| Christy Pelletier | Coastal Horizons |

Guests:

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| Peggy Balak | Triumph |
| Byron Brooks | SE Regional AHEC |
| Margaret Clayton | Five County Mental Health Authority |
| Jeannine King | Mentor |
| Janis Kupersmidt | Innovation Research and Training, Inc. |
| Carlyle Johnson | Wake County Human Services |
| Densie Lucas | Cumberland County |
| Sara McEwen | Governor's Institute |
| Ann Paquette | Triumph |
| Bethania Rorie | Mentor |
| Sabrina Russell | Guilford County |
| Jay Taylor | Pathways |

Staff:

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| Ward Condelli | North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) |
| Becky Ebron | NC DMHDDSAS |
| Ken Marsh | NC DMHDDSAS |
| Mabel McGothlin | NC DMHDDSAS |
| Tom Palombo | NC DMHDDSAS |
| Adolph Simmons | NC DMHDDSAS |
| Helen Wolstenholme | NC DMHDDSAS |
| Jenny Wood | NC DMHDDSAS |
| Karen Eller | North Carolina State University's Center for Urban Affairs and Community Services (NCSU CUACS) |
| Jaclyn Johnson | NCSU CUACS |
| Kathryn Long | NCSU CUACS |

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| Mindy McNeely | NCSU CUACS |
| Bob Hubbard | National Development and Research Institutes, Inc. (NDRI) |
| Marge Cawley | NDRI |
| Gail Craddock | NDRI |
| Deena Medley-Murphy | NDRI |
| Lillian Robinson | NDRI |

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**Meeting Convened**

- Marge Cawley convened the meeting at 10:05 a.m. with self-introductions.

**July 27, 2006 Meeting Minutes Approved**

**DSIS Update**

- Tom Palombo, NC DMHDDSAS, shared updated information on the Division's Decision Support Information System (DSIS). He provided a handout of his presentation. Please contact Cawley@ndri-nc.org for a copy.
- He highlighted six accomplishments of DSIS:
  - Creating the web based data architecture and ad-hoc querying retrieval system
  - Increased access to standard reports
  - Development of web based audio and visual training
  - Creation of a structured web base eclectic data cleaning tool and processing step
  - Structure levels in security and privacy for limited-data set, medical record and public access users
  - Addressing ways to meet future national outcome measures (NOMS)

**Using NC-TOPPS in QI, Wake County as an Example**

- Dave Peterson, Wake County Human Services, shared his upcoming FARO presentation. For a copy of Peterson's Power Point presentation, please contact cawley@ndri-nc.org. The SFY 2006 "Adult Mental Health Consumers Statewide, Initial Assessment Matched to 3-Month Update Assessment July 1, 2005 through June 30, 2006" Report was shared as an example of what each LME or provider can receive if they have enough data. Please go to http://www.ndri-nc.org/StatewideJulJun2006/StatewideMatchedAdultMH.pdf to review the report.
- Peterson began his presentation noting that an LME can use NC-TOPPS data to highlight the LMEs own unique character and outcomes. He built his presentation around Wake's LME Annual Report provided by Gail Craddock, NDRI.
- He highlighted demographic, population groups and diagnosis that showed how Wake's population differs from the rest of the State. He shared areas that Wake could improve, but also commented on areas where Wake was doing well compared to other LMEs. He summarized that these annual reports display

useful information that can be used to tell a story, but also lead to asking more questions that can be further researched. Peterson concluded by sharing his desire to use NC-TOPPS data in conjunction with other information to aid in ways to improve providers meeting rules and protocols for specific populations, such as those consumers served in residential facilities.

**Expansion of NC-TOPPS Online Umbrella - ADATC**

- Jenny Wood and Helen Wolstenholme, Division's State Operated Services Section, discussed the development and purpose of an online version of NC-TOPPS for the Division's Alcohol and Drug Abuse Treatment Centers (ATADCs). They described the collaborative effort of staff from each ADATC and NC-TOPPS contract personnel in composing the ADATC online Interviews. The ADACT: NC-TOPPS is the program by which each ADATC and the NC Division of MHDDSAS measures outcome and performance to show how well the ADATCs are doing.
- Wood and Wolstenholme shared the redesign of ADATCs' services. Based on their strategic planning, the ADATCs decided to introduce evidence-based treatment models and motivational interviewing techniques to meet the complex treatment needs of individuals served in both the acute and sub-acute units. Three tracks have been proposed in the redesign model: 1) skill building; 2) relapse prevention; and 3) co-occurring. Use of these three tracks allows each program to focus on an individual's specific treatment needs while maximizing the effectiveness of treatment by track matching for improved outcomes. Each individual will be continually reassessed to measure both treatment progression and newly identified treatment needs. The ADATC:NC-TOPPS is designed for cross-facility use in order to identify and build on strengths of each program while borrowing and sharing ideas toward growth and improvement. The three ADATC's specialize as follows:
    - Julian F. Keith, Black Mountain, has a 10 bed acute unit
    - R.J. Blackley, Butner, has acute units and a methadone program
    - Walter B. Jones, Greenville, has a 24 bed acute unit and a perinatal program for women and babies.
- The ADATC:NC-TOPPS will capture key information on the patient's current episode of care, will measure motivational change and progress toward treatment goals, will aid in evaluating the quality of service delivery and will provide data for meeting federal performance and outcome measurement requirements.
- They described the measures of readiness for change that are part of the ADATC:NC-TOPPS. It includes Socrates which has 19 alcohol and 19 drug questions; three questions that measure readiness, confidence and conviction to make change(s); and questions that are asked in motivational interviewing language to assess treatment needs.
- They presented their commitment to bridging ADATC and community NC-TOPPS for capturing an individual's continuity of care. They noted that an Episode of Completion is not required by a community provider when a consumer is referred to an ADATC and that the ADATC: NC-TOPPS facilitates the transition of a consumer from one level of care to another.

- Training was provided for Julian F. Keith staff on October 18. R. J. Blackley counselors were trained on October 24 and counselors at Walter B. Jones were trained on October 25. Walter B. Jones anticipates starting implementation on November 6. The other two sites will begin implementation after receiving motivational interviewing and other training.
- The ADATC: NC-TOPPS site is https://nctopps.ncdmh.net/ADATC.htm .
- For a copy of their Power Point handout, please contact cawley@ndri-nc.org.

**Joint Legislative Oversight Committee Statewide System Performance Report, SFY 2006-2007: Fall Report**

- Adolph Simmons and Becky Ebron, Division of MHDDSAS, Quality Team members, distributed copies of the "Mental Health, Developmental Disabilities and Substance Abuse Services Statewide System Performance Report, SFY 2006-07: Fall Report". For a copy of this handout go to the division's website - http://www.ncdhhs.gov/mhddsas/statspublications/reports/locrptstateperformancegoals10-1-06.pdf
- They explained that this type of report will be done every six months as required by Session Law 2006-142, House Bill 2077, Section 2(a)(c). The first report was due to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services by October 1, 2006. This report provided the first comprehensive assessment of the mental health, developmental disabilities and substance abuse services since system transformation began.
- They went through the charts highlighting the various measures selected for this first report. They discussed the importance of the measures and data sources.

**NC-TOPPS as a Clinical Tool**

- Carlyle Johnson, Wake County Human Services Adult Mental Health, shared a well-received presentation on the importance of outcomes in clinical practice. Please contact cawley@ndri-nc.org for his Power Point slides.
- His conversation covered outcomes in Wake County, challenges to implementation, strategies for incorporation of outcomes into clinical practice, clinician and management buy-in, findings and accomplishments and sustaining support.
- Outcomes in Wake County became a focus in 1996 when a unified Human Services Agency was created. Its organizational structure, work objectives and agency priorities reflected the importance of outcomes and commitment to outcomes management. In addition, Wake County implemented an adult mental health outcomes initiative.
- Challenges to implementation include: clinician buy-in and support; relevance to consumers; competition with other priorities; lack of meaningful feedback; lack of consequences for either completion or non-completion and clinician multi-tasking.
- Strategies for incorporating outcomes into clinical practice include developing clear outcomes philosophy and principles; providing support at all levels of the agency; integrating measurement into clinical practice and establishing feedback loops to consumers, clinicians and management/administrators. The outcome

information collected must have immediate value to consumer and clinician in providing treatment. Outcomes evaluation must become part of the treatment process rather than a process added onto the treatment process: "Does collection of data lead to clinically meaningful dialogue between clinician and consumer about progress in treatment and changes needed to attain outcomes?" Data and reports must be relevant, understandable and meaningful to consumers, clinicians and the general public. Data collection must be frequent enough to notice if there is progress, yet not so often as to be burdensome. Instruments must be relatively simple, easy to administer and inexpensive in money and staff time and yet reasonably reliable, valid and sensitive to change. Data at the individual level must be accessible to clinicians and aggregate data must be provided to staff in a timely manner.

- Clinicians and management must buy-in to outcomes management. Clinicians should recognize that they already routinely assess outcomes and that an outcomes management system provides a structured way to capture and use this data. Clinicians need to see how outcomes improve understanding of a consumer and improve the therapeutic relationship. Management needs to see how outcomes aid in better understanding of the consumers they serve and how the organization's services impact consumers. Management needs to assess consumer satisfaction and how outcomes are relevant to national accreditation.
- Johnson described and explained the BASIS-32 outcomes pilot that Wake conducted. They learned from this pilot that the compliance rate was better when outcomes management was paired with a service plan. Clinicians were positive about outcomes data collection and use when able to also use for treatment planning and when the outcomes tool allowed for individualized pre-post assessment of response to treatment.
- Continued support for use of outcome measurement is sustained when it can be incorporated into existing 'tracked events' such as service plan preparation; when immediate clinical relevance can be seen; when aggregate reports can be timely provided to all levels of the treatment provider organization; and when data interpretation is framed in a continuing quality improvement system.

**Increasing Implementation: A Roundtable Discussion**

- Cawley moderated a brainstorming session on increasing NC-TOPPS implementation by providers. In advance of the meeting she had contacted some providers and LME members to think about this issue and to bring ideas, suggestions or solutions to the meeting. The following table summarizes the discussion.

## Increasing NC-TOPPS Compliance

| Barriers to Compliance | Suggestions/Ideas/Solutions |
|---|---|
| Immediate Data Available to Clinical staff | |
| | Pair NC-TOPPS with PCP |
| | Making NC-TOPPS a part of what is required/done by clinical staff and providers (monitoring, auditing, assessment) |
| Discharge Compliance-engagement of consumer who has left services | |
| Providers don't feel they get the feedback from NC-TOPPS | |
| Communicating to providers, LME | |
| Not being able to use the data to replace current system | |
| "Reports" available to clinical staff and super-users | |
| | Advertise Gail's reporting capabilities |
| Handling drop out discharge data-could we make this a shorter version? | Discuss this option with Management Team |
| | Add IPRS Target Populations Definitions as a link |
| Connecting Value Options and EDS info for the LME's | |
| Provider tracking by LME timely | |
| Put pertinent info in super-user 'accounts' | |
| | Copy LME Superuser's when responding to Provider clinicians |

- Members requested setting aside time during upcoming meetings to review this table to determine if any action or change has taken place.

**Other**
None.

**Wrap Up and Adjournment**
- The meeting was adjourned at 2:50 p.m. The next meeting is scheduled for January 25, 2007 from 10 a.m. to 3 p.m. at the NCSU University Club.